JEAN M. SHEPHARD
DIRECTOR

NANCY L. BOWEN, M.D., M.P.H
PUBLIC HEALTH OFFICER

County of San Diego

HEALTH AND HUMAN SERVICES AGENCY

PUBLIC HEALTH SERVICES
MATERNAL, CHILD AND FAMILY HEALTH SERVICES
P.O. Box 85222, San Diego, California 92186-5222
(619) 692-8808 FAX (619) 692-8827

September 10, 2004

Dear Head Start Health Staff:

On November **10, 2004,** Karen Faillace, M.A, CCC/A, Audiologist with Children's Hospital and Health Center, will conduct a CHDP Program Preschool Hearing Screening Workshop sponsored by County of San Diego Training and Development and the Child Health and Disability Prevention (CHDP) Program.

This workshop has been approved by the California Board of Registered Nursing for HHSA Training and Development, Provider #3853, for six (6) contact hours. In order to receive a certificate of completion and CEUs, each workshop participant must attend the all-day lecture.

Each organization will be limited to two (2) participants unless space allows for additional registrants. It is recommended that you send only two staff that have never attended an audiometric workshop or that you feel need a review.

Please complete the enclosed registration form.
Registrations must be received by Monday, October 18th, 2004.

All registered participants will receive notice of confirmation via fax within two weeks of registration including specific details such as site location, time, directions, and parking instructions.

Please feel free to contact me at (619) 692-8486 if you need any further information. Thank you for your time and attention to this matter.

Sincerely,

Erin E. Alleman, MPH
Health Promotion Specialist
Maternal, Child and Family Health Services

Enclosure

AKA
Preschool Hearing Screening Workshop Registration Form

Fall 2004

Reservations must be received by Monday, October 18th, 2004.

Please Print Clearly

Name of Registrant Number One (last, first) _____

Title _____

Site Name: _____

Street Address _____

City_____ Zip Code _____

RN License Number (if requesting CEUs) _____

Contact Telephone Number (_____) _____-_____

Fax Number (required to receive confirmation letter) (_____) _____-_____

Name of Registrant Number Two (last, first) _____

Title _____

Site Name: _____

Street Address _____

City_____ Zip Code _____

RN License Number (if requesting CEUs) _____

Contact Telephone Number (_____) _____-_____

Fax Number (required to receive confirmation letter) (_____) _____-_____

Fax this completed registration form to:

Attn: Michelle Dearborn
Fax (619) 692-8827